STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #28812 were completed on December 12-14, 2011, at Mt Juliet Health Care. Deficiencies were cited related to complaint investigation #28812 under CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain dignity during dining for ten (#1, #11, #13, #15, #23, #24, #25, #26, #27, and #28) of twenty-eight residents reviewed. The findings included: Resident #1 was admitted to the facility on April 7, 2008, with a diagnosis of Parkinson's Disease. Medical record review of the Minimum Data Set (MDS) dated October 10, 2011, revealed the resident scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS-severe impairment) and required extensive assistance with eating. Resident #11 was admitted to the facility on February 6, 2008, with diagnoses including	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Frances Lavoie Administrator 12-29-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Dementia, Renal Failure, Hyponatremia, Osteoarthritis, and Organic Brain Syndrome. Medical record review of the MDS dated November 7, 2011, revealed the resident had short and long term memory problems, was moderately impaired with decision making and required extensive assistance with eating. Resident #13 was admitted to the facility on April 9, 2009, with diagnoses including Dementia and Dysphagia (difficulty swallowing). Medical record review of the MDS dated November 22, 2011, revealed the resident had short and long term memory problems, was severely impaired with decision making and required total assistance with eating. Resident #15 was admitted to the facility on October 27, 2008, with diagnoses including Muscle Weakness and Neurotic Disorders. Medical record review of the MDS dated November 22, 2011, revealed the resident had short and long term memory problems, was severely impaired with decision making and required total assistance with eating. Resident #23 was admitted to the facility on January 7, 2008, with diagnoses including Dementia, Cerebral Vascular Accident (CVA) with Right Side Hemiparesis (weakness). Medical record review of the MDS dated October 17, 2011, revealed the resident had short and long term memory problems, was severely impaired with decision making and required	F 241	483.15(a) Dignity and Respect of Individuality SS=E Requirement: The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action: 1. Resident's #1, #11, #13, #15, #23, #24, #25, #26, #27 and # 28 will be assisted during meals in a 2:1 ratio by staff to promote dignity. 2. Residents in the facility have been reassessed by Nurse Management and the Dietary Supervisor to determine level of assistance during meal times. Seating charts and meal times were reviewed and revised on 12/27/11 by the DON and Risk Management. 3. The nursing staff was in-serviced by the DON and Risk Management Nurse on 12/14/11 and 12/29/11 regarding enhancing resident's dignity and the new dining room procedures. 4. Dining room practices will be monitored weekly by the DON/ADON and Dietary Supervisor. Review of mealtime procedures and seating chart will be reported to the QA committee.	12/29/2011

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F 241	Continued From page 2 extensive assistance with eating. Resident #24 was admitted to the facility on August 15, 2005, with diagnoses including Dementia, Diabetes Mellitus, and Osteoarthritis. Medical record review of the MDS dated November 8, 2011, revealed the resident had short and long term memory problems, was severely impaired with decision making and required extensive assistance with eating. Resident #25 was admitted to the facility on April 14, 2010, with diagnoses including Dementia, Diabetes Mellitus, and Hypoglycemia. Medical record review of the MDS dated September 29, 2011, revealed the resident had short and long term memory problems, was severely impaired with decision making and required limited assistance with eating. Resident #26 was admitted to the facility on February 11, 2011, with diagnoses including Dementia, Diabetes Mellitus, and Mitral Value Prolapse. Medical record review of the MDS dated November 18, 2011, revealed the resident scored 3 out of 15 on the BIMS (severe impairment) and required extensive assistance with eating. Resident #27 was admitted to the facility on March 30, 2009, with diagnoses including Dementia, Chronic Anemia, and Osteoarthritis. Medical record review of the MDS dated November 18, 2011, revealed the resident had	F 241		

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F 241	Continued From page 3 short and long term memory problems, was severely impaired with decision making and required total assistance with eating. Resident #28 was admitted to the facility on December 1, 2011, with diagnoses including Renal Failure, Dementia, and Anemia. Medical record review of the MDS dated December 8, 2011, revealed the resident had short and long term memory problems, was moderately impaired with decision making and required limited assistance with eating. Observation on December 12, 2011, at 12:46 p.m., in the dining hall, revealed five residents (#1, #11, #13, #15, #25) seated at table #7 and #8. Continued observation revealed CNT #1 (Certified Nursing Technician) sitting on a rolling chair between table #7 and #8 feeding resident #11 two bites of food and then feeding resident #15 two bites of food and then feeding resident #13 two bites of food. Continued observation revealed CNT #1 would roll on the chair in between the residents, turning back to one resident while feeding another and each resident would have to wait for the CNT to spin back around in turn for their next bite of food. Continued observation revealed CNT #1 did not offer any food to resident #1 from 12:46 p.m. to 12:56 p.m. Continued observation revealed resident #25 fell asleep on two occasions with the resident's forehead falling into the plate of food. Observation on December 13, 2011, at 12:23 p.m., revealed six residents (#23, #24, #26, #27, #28) in the dining hall seated at table #1 and #2. Continued observation revealed CNT #5 sitting	F 241		

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F 241	Continued From page 4 on a rolling chair between table #1 and #2 feeding resident #27 two bites of food and then turning around and feeding resident #23 two bites of food and then turning back around to feed resident #24 two bites of food. Continued observation revealed CNT #5 to roll on the chair in between the residents, turning back to one resident while feeding another, and each resident would have to wait for the CNT to spin back around in turn for their next bite of food. Continued observation revealed CNT #5 did not offer any food to resident #26 or resident #28 until 12:32 p.m. Interview with CNT #1 on December 12, 2011, at 1:03 p.m., in the dining hall confirmed it was normal procedure for the CNT to feed the residents in this manner. Interview with Director of Nursing (DON) on December 12, 2011, at 1:08 p.m., in the dining hall, confirmed the residents' dignity had not been maintained. Interview with CNT #6 on December 13, 2011, at 08:38 a.m., in the dining hall, confirmed residents sitting at tables #1 through #10 needed assistance with eating.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	483.15(e)(1) Reasonable Accommodation of Needs/Preferences SS=D Requirement: A resident will have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	

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F 246	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the call light was in reach for one resident (#18) of twenty-eight residents reviewed. The findings included: Observation on December 12, 2011, at 9:35 a.m., revealed the resident resting in bed and the call light cord extended along the side of the bed toward the resident but with no call button visible. Continued observation revealed when the resident reached for the call light, the end was lodged in the bed, and the resident could not pull it out to push the call button. Observation and interview with the Director of Nursing (DON) on December 12, 2011, at 9:40 a.m., in the resident's room, after the verbal call for assistance, revealed the DON lifted the call button from between the linens and the bed rail to put it in reach for the resident and confirmed the call light was not available to the resident.	F 246	Corrective Action: 1. The call light was placed in reach for Resident #18 by Director of Nursing on 12/12/11 at 9:35am. 2. Audit was conducted by Risk Management Nurse on 12/27/11 to ensure that all patients had call lights in reach and accessible to patients. 3. The DON in-serviced the nursing staff regarding call light placement and accessibility on 12/15. 4. Random rounds will be conducted weekly by the DON and ADON to ensure compliance of call light placement the findings will be reported to the QA committee. 483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP SS=D Requirement:	12/29/2011
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the residents legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment	

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F 280	Continued From page 6 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for one resident (#1) of twenty-eight residents reviewed. The findings included: Resident #1 was admitted to the facility on April 7, 2008, with diagnoses including Seizure Disorder, Hypertension, Depression, Parkinson's Disease, and a History of Falls. Medical record review of the Minimum Data Set completed for a significant change on October 10, 2011, revealed the resident scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status, the resident required two persons for assistance with all activities of daily living, and the resident did not ambulate. Medical record review of the care plan dated October 17, 2011, revealed "...Transfer in and out of bed as needed: extensive assist 1-2 staff..."	F 280	Corrective action: 1. The care plan for resident # 1 was updated on 12/13/11 to reflect that the resident is to be transferred with two person assistance. 2. MDS coordinators completed the care plan audit on 12/29/11 to ensure that care plans were updated and accurate. 3. MDS coordinators were in-serviced by the DON on 12/29/11 regarding updating care plans timely and accurately. 4. ADON/DON will perform weekly audits to ensure that care plans are updated and followed, the findings will be reported to the QA committee.	12/29/2011

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F 280	Continued From page 7 Medical record review of the physician's recapitulation orders, signed by the physician on November 27, 2011, revealed "...Use Sarsh (Sara) lift for transfers..." Medical record review of the Messages Detail Report dated December 13, 2011, (utilized by the staff to know what care to provide residents) revealed "...2-person transfer and/or Hoyer lift.." Observation on December 13, 2011, at 4:00 p.m., in the resident's room, revealed two Certified Nurse Technicians (CNT #3, CNT #4) transferred the resident from the bed to a chair using a gait belt around the resident's waist, and pivoted the resident while standing without the use of a mechanical lift. Interviews with CNT #3 and CNT #4 on December 13, 2011, at 4:05 p.m., in the resident's room, confirmed the CNTs transferred the resident from the bed to the chair with two persons with use of a gait belt and a pivot transfer, and did not use a Sara or Hoyer lift. Interview with Registered Nurse #2 on December 13, 2011, at 4:20 p.m., at the nursing station, confirmed the resident's care plan had not been revised to include the use of a Sara lift when transferring the resident.	F 280		
F 312 SS=D	C/O #28812 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	483.25(a)(3) ADL Care Provided for Dependent Residents Requirement: The facility will insure that all residents receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene	

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F 312	Continued From page 8 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide assistance with eating for one resident (#26) of twenty-eight residents reviewed. The findings included: Resident #26 was admitted to the facility on February 11, 2011, with diagnoses including Dementia, Diabetes Mellitus, and Mitral Value Prolapse. Medical record review of the Minimum Data Set (MDS) dated November 8, 2011, revealed the resident scored 3 out of 15 on the Brief Interview for Mental Status (BIMS - cognitively impaired) and required extensive assistance with eating. Medical record review of the Plan of Care dated March 2011, revealed interventions to include tray set up with all meals and assist as needed. Observation on December 13, 2011, at 12:23 p.m., revealed six residents (#14, #23,#24, #26,#27, #28) in the dining hall seated at table #1 and #2. Continued observation revealed CNT (Certified Nursing Technician) #5 sitting on a rolling chair and would roll on the chair between table #1 and #2 feeding resident #27 two bites of food then turn the back toward resident #27 to feed resident #23 two bites of food and then turn the back toward resident #23 to feed resident #24	F 312	Corrective Action: 1. On 12/14/11resident #26 was reassigned on the seating chart in the dining room to be fed by staff at all meals. The seating chart was revised to accommodate feeding ratio of 2:1 by nursing staff. 2. An audit of residents that require assistance with eating was conducted by the DON and Risk Management Nurse by 12/28/11. The residents who require extensive to total assistance will be brought to the dining room in groups of eight at two different times to accommodate the 2:1 feeding schedule. Seating charts and meal times were reviewed and revised on 12/27/11 3. Nursing staff in-serviced on 12/29/11 by the DON and Risk Management Nurse regarding the new dining room procedures. 4. Dining room practices will be monitored weekly DON/ADON and Dietary Manager. Changes will be made to seating chart as determined by resident needs and findings will be reported to the QA committee.	12/29/2011

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F 312	Continued From page 9 two bites of food. Continued observation revealed CNT #5 did not offer any food to resident #26 until 12:32 p.m. During this period of time resident #26 was watching CNT #5 feed the other residents. Interview with the Director of Nursing (DON) on December 13, 2011, at 12:35 p.m., in the dining hall, confirmed the residents had to wait for assistance with feeding because one CNT had to assist two tables with meals and one CNT "can't feed multiple residents at once."	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety measures were in place for one (#4) of twenty-eight residents reviewed. The findings included: Resident #4 was admitted to the facility on August 14, 2011, with diagnoses including History of Falls, Osteopenia, and Dementia. Medical record review of a Fall Risk Assessment	F 323	483.25(h) Free of Accident Hazards/Supervision/Devices Requirement: The facility will insure that the resident environment remain as free of accident hazards as possible and each resident will receive adequate supervision and assistive devices to prevent accidents Corrective Action: 1. On 12/13/11 the bed of resident # 4 was immediately lowered to the lowest position and the mats were put in place by the Licensed Practical Nurse. 2. An audit was conducted by Nurse Management on 12/13/11 to ensure safety interventions are in place as ordered. 3. The nursing staff was in-serviced on 12/13/11 and 12/29/11 by the DON regarding following safety interventions as ordered.	

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F 323	Continued From page 10 dated August 15, 2011, revealed the resident was at high risk for falls. Medical record review of the Care Plan reviewed on November 28, 2011, revealed "...Risk for falls, secondary to confusion, weakness, poor balance...Low bed with mats..." Medical record review of the December 2011, physician's recapitulation orders revealed "...Low bed with mats..." Observation on December 13, 2011, at 9:10 a.m., revealed the resident lying on the bed. Continued observation revealed the right side of the bed was against the wall, the bed was not in the lowest position, and there was no fall mat on the left side of the bed. Observation and interview on December 13, 2011, at 9:15 a.m., with Licensed Practical Nurse (LPN) #8, revealed the resident lying on the bed and confirmed the bed was not in the lowest position and the fall mat was not in place.	F 323	4. The DON and ADON will monitor for compliance weekly through facility rounds and observation. Nursing staff to monitor daily for compliance. The findings will be reported to the QA committee.	12/30/2011
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	483.60(a), (b) Pharmaceutical SVC-Accurate Procedures, RPH SS=D Requirement: The facility will provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in of this part. The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biological to meet the needs of each resident. The facility will employ or obtain services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	

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F 425	Continued From page 11 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure medications were acquired and administered for three residents (#6, #7, #14) of twenty-eight residents reviewed. The findings included: Resident #6 was admitted to the facility on March 4, 2011, with diagnoses including Major Depression, Multiple Sclerosis, and Acute Renal Failure. Medical record review of the physician's recapitulation orders for October 2011, revealed "...methylphenidate (Ritalin) 5 mg (milligrams) take one and one-half tab (tablet)...by mouth three times daily..." Medical record review of the October 2011 medication administration records revealed "...date October 15, 2011, and October 16, 2011, medication not given reason...not available..." Interview by telephone with Charge Nurse #2 on December 14, 2011, at 9:38 a.m., confirmed the	F 425	Corrective Action: 1. The medications for Residents # 6, #7, #14 were checked on the cart by the licensed nurse and available for administration on 12/14/11. 2. Mars were reviewed by the DON for all patients in the facility on 12/28/11 to ensure that medications were administered. 3. Staff nurses were in-serviced on 12/14/2011 by the DON regarding pharmacy procedures and auditing of the med carts to ensure timely delivery of all medications. 4. ADON/DON will audit MAR's on a weekly basis to insure medications are being given as ordered.	12/30/2011

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F 425	Continued From page 12 medication was not available to give and the medication was not administered on October 15 and October 16, 2011. Resident #7 was admitted to the facility on February 4, 2008, with diagnoses including Hypertension, Rheumatoid Arthritis (RA), Depression, Chronic Obstructive Pulmonary Disease (COPD), and Osteoporosis. Medical record review of physician's orders revealed the following: February 8, 2008, Advair Diskus (used to treat COPD) 100/50 mcg (micrograms), one puff twice daily; November 9, 2009, Fosamax (used to treat bone loss) 70mg tablet, one tablet by mouth every 7 days; December 10, 2010, Lidoderm (used to treat pain) 5% Topical Patch, apply to left hip and right shoulder every day (on at 5 a.m. and off at 5 p.m.); June 17, 2011, Neurontin (used to treat pain) 100mg capsule, take two capsules by mouth three times a day; and June 18, 2011, Vitamin-D (used to treat bone loss) 50,000 units, take one capsule by mouth every 7 days. Medical record review of the Medication Administration Record (MAR) dated June 2011 revealed the resident did not receive Fosamax on June 3, 2011; or the Advair Diskus on June 20, 21, and 22, 2011. Medical record review of the MAR dated July 2011 revealed the resident did not receive Vitamin D on July 26, 2011. Medical record review of the MAR dated August 2011 revealed the resident did not receive	F 425		

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F 425	Continued From page 13 Fosamax on August 26, 2011, or the Lidoderm patch on August 7, 8, 9, and 10, 2011. Medical record review of the MAR dated September 2011 revealed the resident did not receive Fosamax on September 2, 9, 16, and 30, 2011, Lidoderm patch on September 12, and 13, 2011, Advair on September 13, 2011, or Vitamin -D on September 13, 2011. Medical record review of the resident's MAR dated December 2011 revealed the resident did not receive Fosamax on December 11, 2011. Telephone interview with Licensed Practical Nurse (LPN) #5 on December 13, 2011, at 6:37 p.m., confirmed the medications had been ordered but had not been received from pharmacy and the medications were not administered because they were not available. Telephone interview with LPN #6 on December 14, 2011, at 6:08 a.m., confirmed the medications had been ordered but had not been received from pharmacy and the medications were not administered because they were not available. Interview and observation with LPN #3 on December 14, 2011, at 7:45 a.m., at the 300 Hall medication cart, confirmed the resident's Fosamax package was empty and no medication was available since the last pharmacy delivery of four doses on October 31, 2011. Interview with the Director of Nurses (DON), on December 14, 2011, at 7:25 a.m., in the DON office, confirmed the medications were not administered as ordered because they were not	F 425		

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F 425	Continued From page 14 available from the pharmacy. Resident #14 was admitted to the facility on December 6, 2007, with diagnoses including Anemia, Dementia, and Seizure Disorder. Medical record review ofa physician's order dated December 6, 2007, revealed Aranesp Injection (used to treat anemia) 100mcg/ml (microgram/milliliter), one milliliter subcutaneous every month (do not give unless hematocrit is less than 30, and Vitamin B 12 Injection (used to treat anemia) 1,000mcg/ml, one milliliter every month. Medical record review of the MAR dated August 2011 revealed the Vitamin B 12 Injection was not administered on August 15, 2011. Medical record review of the MAR dated September 2011 and the resident's hematocrit dated September 15, 2011, revealed the resident's hematocrit was 28.4 (38.0-50.0) (indicating Aranesp was to be administered) and the Aranespt was not administered. Interview with the DON on December 14, 2011, at 7:25 a.m., in the DON office, confirmed medications were not administered because they were not available from pharmacy.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431	483.60(b), (d), (e), Drug Records, Label/Store Drugs & Biologicals Requirement: The facility will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	

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F 431	Continued From page 15 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of Tennessee Pharmacy Laws 2008 Edition, and interview, the facility failed to ensure the contents of emergency medication boxes for residents were secured in one (White Night Cabinet Emergency Box) of four emergency boxes observed, and correctly label a medication	F 431	accurate reconciliation; and will determine that drug records are in order and than an account of all controlled drugs is maintained and periodically reconciled. Drugs and biological used in the facility will be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable. In accordance with State and Federal laws, the facility will store all drugs and biological in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility will provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single dose distribution systems in which quantity stored in minimal and a missing dose can be readily detected. Corrective Action: 1. The White Night cabinet emergency box was immediately locked by the Licensed Practical Nurse on 12/12/11. b. Medications orders for resident #14 were reviewed with pharmacy consultant by the DON on 12/14/11 and the correct dose of Trazadone was sent before the next dose was due.	

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MT JULIET HEALTH CARE CENTER	2550 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

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F 431	Continued From page 16 for one (#14) of twenty-eight residents reviewed The findings included: Observation of the White Night Cabinet Emergency Box on December 12, 2011, at 2:25 p.m., in the Main Medication Room with Licensed Practical Nurse (LPN) #1 revealed the key was inserted into the lock. Further review of the list of contents of the White Night Cabinet Emergency Box revealed 1002 doses of 186 medications including antibiotic medications (Levaquin); medications for blood pressure (Amlodipine); antipsychotic medications (Seroquel); and blood thinners (Warfarin) were available for emergency use for residents. Review of facility policy, Night Cabinet Procedures, revealed "...2. If the night cabinet is used a licensed nurse must open the cabinet, remove the required medication, record the use of medication, secure Night Cabinet (must be kept in MED. PREP ROOM), notify pharmacy by next working day..." Review of the Tennessee Pharmacy Laws 2008 Edition Rule 1140-4-.09 Emergency and Home Care Kits documented "...(3) The emergency kit shall be provided sealed or electronically secured by authorized personnel in accordance with established policies...10. When an emergency kit is opened for any reason...the kit shall be...resealed...so as to prevent risk of harm to patients..." Interview with LPN #1 on December 12, 2011, at 2:30 p.m., in the Main Medication Room, confirmed the key to the White Night Cabinet Emergency Box was in the lock and the contents	F 431	2. The facility medication boxes and carts were inspected by the DON to ensure that all were securely locked. b. An audit was completed on 12/28/11 on the resident Mars by the DON and the Risk Management Nurse on to ensure that all patients took their appropriate dose of medications. 3. Licensed nurses were in-serviced on 12/14/2011 to keep the contents of the night cabinet locked at all times. Licensed nurses were in-serviced in reviewing MAR's to medication packaging to insure the correct dose of medication will be given to the resident as ordered 4. Random audits will be conducted by the ADON to monitor for accuracy and compliance. findings will be reported to the QA committee.	

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F 431	Continued From page 17 of the emergency box were not secured. Telephone interview with the Lead Pharmacy Consultant, on December 14, 2011, at 9:58 a.m., confirmed the key to the White Night Cabinet Emergency Box shall not be stored in the lock and the contents were not secured per facility policy. Resident #14 was admitted to the facility on December 6, 2007, with diagnoses including Anemia, Dementia, and Seizure Disorder. Medical record review of the Medication Administration Records and Physician's recapitulation orders for November and December 2011, revealed "...Trazodone tab (tablet) 50 mg (milligrams), one-half tablet (note dose) (12.5mg) by mouth at bedtime..." Interview and observation with Registered Nurse #1 on December 14, 2011, at 9:20 a.m., at the 400 Hall medication cart, confirmed the Trazodone package was labeled as 50mg, to administer one half tablet at bedtime, and would not be a correct dosage of 12.5mg if a 50mg tablet was cut in half. Interview with Director of Nurses (DON) on December 14, 2011, at 10:55 a.m., in the DON office, confirmed the medication was not labeled correctly to accurately administer 12.5mg.	F 431		12/30/2011
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	483.65 Infection Control, Prevent Spread, Linens SS=D	

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F 441	Continued From page 18 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	Requirement: The facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Corrective Action: 1. The licensed wound nurse was in-serviced on 12/14/2011 on effective hygiene before donning gloves and after removing gloves. The CNT was in-serviced on washing hands after patient contact during meals. 2. ADON/DON will observe a random wound change each week to ensure infection control standards are being followed. 3. All staff were in-serviced 12/15/2011 and 12/16/2011 on hand washing and/or using hand sanitizer during meals to insure infection control standards are being followed. 4. ADON/DON will observe a random meal each week to insure staff are following infection control guidelines and findings will be reported to the QA committee.	

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F 441	Continued From page 19 by: Based on observation, facility policy review, and interview, the facility failed to appropriately wash the hands during a dressing change for one resident (#3), and failed to appropriately wash the hands prior to touching the food for one resident (#22) of twenty-eight residents reviewed. The findings included: Observation on December 12, 2011, at 1:05 p.m., revealed Licensed Practical Nurse (LPN) #3 providing wound care to resident #3. Continued observation revealed the following: LPN #3 washed the hands and donned gloves; cleaned a wound on the left buttock with saline and a gauze pad, described the wound as a Stage II pressure ulcer, measuring 1.5 cm (centimeters) in length, and 0.4 cm in width, with serous drainage; without changing the gloves or washing the hands cleaned a wound on the right buttock with saline and a gauze pad, and described the wound as a Stage II pressure ulcer measuring 1.1 cm in length, and 0.6 cm in width, with excoriated skin surrounding the pressure ulcer; changed the gloves and without washing the hands applied ointment and dressings to the two Stage II pressure ulcers; changed the gloves and without washing the hands applied ointment to a rash on the bilateral shoulders; removed the gloves, washed the hands, and exited the resident's room. Review of the facility's Hand Hygiene policy revealed "Hand hygiene is the simplest, most effective means of infection control. The term hand hygiene refers to actions intended to decrease the number of contamination	F 441		

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F 441	Continued From page 20 microorganisms on the skin. Effective hand hygiene is achieved through handwashing with soap and water...Hand hygiene must be performed at a minimum...Before donning gloves and after removing gloves..." Interview on December 12, 2011, at 1:40 p.m., with LPN #3, in the Director of Nursing's office, revealed the hands are to be washed after cleansing a wound prior to cleansing additional wounds, and each time gloves are removed, and confirmed the hands were not washed appropriately during the dressing change for resident #3. Resident #22 was admitted to the facility on August 8, 2007, with diagnoses including Anemia, Dementia, and Congestive Heart Failure. Observation on December 14, 2011, at 8:15 a.m., in the dining hall, during breakfast, revealed Certified Nursing Technician (CNT) #1 rubbed the back of resident #25 with ungloved hands and then used the dining hall phone. Further observation revealed CNT #1 without washing the hands or applying gloves, picked up the toast for resident #22, buttered the toast, and gave the toast to resident #22. Interview with the Director of Nursing (DON) on December 14, 2011, at 9:30 a.m., at the nurses' station, confirmed hand sanitizer is available in the dining hall and was to be used before handling resident food.	F 441		12/30/2011
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	483.70(h) Safe/Functional/Sanitary/Comfortable Environment SS=D	

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F 465	Continued From page 21 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a sanitary environment in two of nineteen resident rooms and the central bath of the 300 Hall. The findings included: Observation on December 12, 2011, at 10:55 a.m., on the 300 Hall, revealed a thick accumulation of black substance around the baseboards outside the bathrooms of room 311 and room 313. Further observation revealed a thick accumulation of a black substance along the baseboards and behind the entry door of the central bath. Interview and observation with the Maintenance Director on December 13, 2011, at 3:50 p.m., in the 300 Hall Central Bath confirmed the floors and corners were not clean. Further interview and observation in room 311 confirmed "... this is an accumulation of dirt being buffed with a buffer." Further interview and observation in room 313 confirmed "...this is mold and will require I replace the drywall..."	F 465	Requirement: The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Corrective Action: 1. The Maintenance Director cleaned and replaced the baseboard outside the bathrooms of room 311, room 313 and the 300 hall central bath on 12/12/11. 2. The maintenance Director checked the baseboards throughout the facility to ensure they were cleaned and maintained properly on 12/13/11. 3. The Maintenance Director and the housekeeping staff were in-serviced by the Administrator regarding proper cleaning and maintenance of the facility baseboards on 12/30/11. 4. The Administrator and the Maintenance Director will monitor for compliance weekly through walking rounds and observation and findings will be reported to the QA committee.	12/15/2011